

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-022008  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 690  
FILED JUN 18 1962

VS 300  
Rev. 4/59

15117

25117

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

C.C. DuMont, M.D.  
BY AFFIDAVIT OF MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 15 Yrs	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 703 Hall St.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EMMA GAA		4. DATE OF DEATH Month Day Year June 12, 1962	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Private Homes & Hospitals Sandusky, Ohio	
13a. FATHER'S NAME Joseph Gaa		13b. MOTHER'S MAIDEN NAME Margaret Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [redacted]	
17. INFORMANT Mike Gaa		Address Maryville, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Cerebral Vascular accident 14 hypertension under		INTERVAL BETWEEN ONSET AND DEATH 20 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour. Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20f. CITY, TOWN, OR LOCATION 1960 to 6-12-62		COUNTY STATE	
21. I attended the deceased from 3:00 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Clemens C. DuMont M.D.		22b. ADDRESS St Joseph Mo	
22c. DATE SIGNED 6-13-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 15, 1962	23c. NAME OF CEMETERY OR CREMATORY St Columbin Cemetery	23d. LOCATION (City, town, or county) (State) Conception, Mo.
24. FUNERAL DIRECTOR H. D. Sidenfader & Son R.D.		25. DATE RECD. BY LOCAL REG. June 15, 1962	
26. REGISTRAR'S SIGNATURE Mr. Clark Handell			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

*Robert H. Gaph*

Licensed Embalmer No. 3308

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

- If this body is not embalmed, fact should be so stated above.